The Hampden Hippocrat

FEBRUARY 1970

DENVER '69

Nov 30-Dec 3, 1969

DENVER '69

AMA

23rd Clinical Convention

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The Hampden Hippocrat

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Medical Society

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IS IT ALREADY TOO LATE?

Of late fiscal intermediaries for Medicare have been rejecting large numbers of claims submitted by hospitals, extended care facilities, and home health agencies ostensibly under directives issued by the Social Security Administration. In Massachusetts, Blue Cross as a Part A intermediary, has issued detailed guidelines of various levels of care for which payment will or will not be made in each respective facility despite certification by attending physicians and physician utilization review committees as to medical need. All this is being done under a *"simple" insurance principle* that a service is either covered or not covered. Blue Cross claims that it is contractually obliged to determine if specific services prescribed by a physician and rendered meet in fact the criteria of skilled services on a continuous basis under the Medicare law. "A skilled service is one which must be furnished by or under the supervision of trained medical or paramedical personnel to assure the safety of the patient and achieve the medically desired result." On the other hand, "a nonskilled service is one which can be safely or adequately self-administered or performed by the average, rational, nonmedical person, without the direct services of trained medical or paramedical personnel." The covered or noncovered (payment or nonpayment) determination is made by Blue Cross personnel of varying qualifications and is considered simply an insurance decision. Moreover, the decision to pay or not to pay is not *incompatible* with a physician's or utilization review committee's determination as to the medical necessity for such services. Needless to say, if a service is not paid for, then the implication is that the service is not necessary, and in turn the implication of the latter for the physician has wide negative parameters.

Blue Cross is very careful to point out that its concern is primarily with payment for services covered by Part A of Medicare and in no way infringes on physician services covered under Part B. Moreover, it claims no incompatibility between an attending physician's right to diagnose and reasonably prescribe needed treatment and its determination to pay or not pay for such treatments. Of course, the next step is for the Part B intermediary to determine whether payment is to be made or not made for the physician's services. What criteria will be evolved by the Part B intermediary in determining payment or nonpayment to a physician for prescribing services determined as not covered under Part A and hence implied as being unnecessary?

Obviously, an attempt is being made to conserve funds of the Medicare Program, but principles and precedents are being set which will have wide ramifications. There is an old saw to the effect that he who pays the piper will call the tune. The principle enunciated above is opening the flood-gates to all third party payees to decide what will be done medically to and for their clients through the power of the purse and irregardless of attending physicians' and peer review committees' determinations of medical necessity. Most patients, if not all, are covered or soon will be by third party payees or intermediaries. Will the latter prescribe and treat too?

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DENVER '69

(Editor's Note — The following are highlights of actions of the AMA's House of Delegates meeting at the 23rd Clinical Convention in Denver, Colorado, from November 30 to December 3, 1969, as issued from the office of the AMA's Executive Vice President.)

In what doubtless will become a historically significant meeting, the AMA House of Delegates at its 23rd Clinical Convention adopted a series of recommendations to provide care for the nation's poor; set in motion a process to make long-range planning and development a permanent program of the Association; issued a clear-cut statement on marijuana; and voted to discontinue the AMA-ERF's Institute for Biomedical Research as soon as its Board of Directors deems feasible.

Those actions, among many others, resulted from the House's consideration of 99 items of business: 22 reports from the Board of Trustees; 3 special reports; 1 from the Council on Constitution and Bylaws; 5 from the Council on Medical Education; 2 from the Council on Medical Service; and 66 resolutions (5 of which were memorials).

PRESIDENT'S ADDRESS

At the opening session of the House, President Dorman challenged the AMA to establish or see to the establishment of a workable system of patient care for all the people of the nation; and to strengthen the Association itself by making it relevant to all physicians.

Regarding the first of those, the president said "the AMA can serve the best interests of physicians only when we serve those of the patient first. We are banded together to make ourselves more effective physicians so that we can serve our patients better."

He emphasized that "In the decade ahead" (a decade he titled "The Significant Seventies") "the AMA must

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become—and prove to the public through visible action that it has become—more patient oriented."

In so doing, he said, medicine must take on the challenges of problems such as the alcoholic, the drug user, the fat man, the smoker and the drunken driver.

Dr. Dorman added that meeting all of the problems calls for a "separate, cabinet-rank department of health, drawing together all health activities of the government under one roof."

Regarding the AMA itself, the president said the Association has concentrated on being an organization for the physician in private practice. Now, he added, it must strive to attract physicians who are educators, researchers, administrators and in federal service.

Another segment of the medical profession that must be attracted is the future physician, Dr. Dorman said. The AMA must find ways "to attract medical students, interns, residents and other young physicians." Anticipating objections, he said "we need to face up realistically to the fact that although we don't like the criticism of some of the younger members and would-be members of our profession—and perhaps we don't approve of the leftward lean of some of their politics —these young professionals are nonetheless as much, or more, patient oriented than some of us."

To accomplish the AMA's goals, Dr. Dorman warned that we may have to alter certain of our cherished traditions. We must be prepared to accept and support totally new ideas, whether we devise them or they are devised by somebody else, providing they work well after adequate trial."

HEALTH CARE OF THE POOR

The House adopted these statements of policy, many parts of which are reaffirmation of existing policy:

"It is a basic right of every citizen to have available to him adequate health care; it is a basic right of every citizen to have a free choice of physician and institution . . . the medical profession, using all means at its disposal, should endeavor to make good medical care available to each person."

"The medical profession must take the leadership and actively support constructive community efforts to eliminate those conditions that adversely affect health."

"The health problems of the poor are basically community health problems, and . . . programs must be adapted to local needs."

"Health care for the poor should not be disassociated from but rather should be a vital part of, the overall health care system."

The adopted report contained these recommendations:

Increased funding of effective gov-

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ernment programs for the health care of the poor and medically indigent; multiple-year funding and private programs to eliminate unfavorable environmental conditions, particularly in disadvantaged areas; AMA support of and participation in a number of experimental projects to develop and evaluate innovative methods of health care delivery with a variety of provider reimbursement mechanisms.

Increase of physician services in urban slum areas by joint AMA-governmental action for a volunteer physician recruitment program for service in areas of need (a Project USA counterpart of the Volunteer Physicians for Vietnam); by support of medical school scholarships provided by state and county medical societies for students from disadvantaged families, in the hope they will return to practice in areas of need; and by permitting part-time practice elsewhere by "full-time" physicians employed by government funded programs for the poor, provided such practice does not interfere with effective service to the poor community.

Expansion of health careers by increasing recruitment from disadvantaged areas; increased attention by medical schools to all aspects of community medicine; development of educational materials for disadvantaged people in language that reflects their cultural backgrounds and living conditions; emphasis on prenatal and postnatal care and preventive care for infants; wider dissemination of family-planning counseling and supplies for those who want them; cooperation with medical and allied health organizations and student medical associations to improve delivery of health services to the poor.

Improved transportation for poor paitents; adequate foods and diets of good nutritional quality for low-income families; enforcement of existing federal and local authority to halt quackery, especially that which exploits the poor; programs to raise the level of mental health services for the poor; and increased participation of minority group physicians in AMA activities.

PLANNING AND DEVELOPMENT

The House accepted a report of the Board of Trustees which announced its formation of a Committee on Program Priorities to work closely with its Finance Committee to evaluate present and future utilization of the resources of the AMA.

After considerable reference committee and House floor debate on the report of the Committee on Planning and Development (both the majority and minority reports), the House voted:

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(1) To establish an ad hoc Committee on Long Range Planning and Development. Its membership is nine, appointed as follows: one from the Board of Trustees; five from the House; one from SAMA; and two from the AMA membership at large.

The ad hoc committee will receive the majority and minority reports, all reviews and correspondence on the subject and the transcript of the proceedings of the reference committee that considered both reports. It will study and make recommendations concerning the structuring of and the change to a permanent Committee on Long Range Planning and Development and report those recommendations to the House at the 1970 Annual Convention.

(2) To send the majority and minority reports "to the component state societies for such specific action by their governing bodies as they deem warranted, it being understood that the resolutions so generated and all recommendations made in the reports (majority and minority) will be considered by the appropriate reference committees at the Annual Convention of 1970."

STATEMENT ON MARIJUANA

The House adopted a policy statement on marijuana which includes the following points:

"Cannabis (marijuana) is a dangerous drug and as such is a public health concern. It is a psychoactive substance which can have a marked deleterious effect on individual performance and social productivity. A significant number of exposed persons become chronic users with concomitant medical and interpersonal problems."

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"The sale and possession of marijuana should not be legalized . . . if all controls on marijuana were eliminated potent preparations would dominate the market, and if the potency were legally controlled, predictably there would be an illicit market for the more powerful forms—leading to more serious medical and social consequences."

"The handling of offenders should be individualized. . . . Where penalties are required the courts should have sufficient discretion to deal flexibly with violators. . . ."

"Additional research on marijuana should be encouraged. . . ."

"The AMA should continue its educational programs to all segments of the population with respect to the use of marijuana. . . . Physicians, frequently and forcefully, should call attention to the problems of all forms of drug abuse and drug dependence, including those which arise from the use of marijuana."

AMA-ERF INSTITUTE FOR BIOMEDICAL RESEARCH

On the reluctant recommendation of the AMA-ERF Liaison Committee of the House of Delegates, and after hearing much praise of the work of the Institute for Biomedical Research, the House adopted the following:

"Whereas, your committee recognizes the vast sums of monies that would be involved in the transfer of the present site of the Institute for Biomedical Research to an area adjacent to the University of Chicago; and . . . acknowledges the multimillion dollar cost to AMA for maintenance and operation if such a move were made; and . . . the possibility of obtaining outside funds . . . is unpredictable; and . . . the current cost of maintaining the Institute at its present location is constantly rising, with no predictable sources of outside funds being available, and without an increase in dues; therefore be it resolved that the Institute for Biomedical Research be discontinued as soon as the Board of Directors of AMA-ERF deems feasible. . . ."

PRIVATE PRACTICE OF MEDICINE

In response to a special report and two resolutions, the House took the following action to support private practice:

"Whereas, the private practice of medicine is still believed to be the best method of serving mankind's medical needs; and . . . there is no specifically designated method in organized medicine for the promotion of private practice; therefore be it resolved that the House of Delegates establish a Committee on Private Practice, which shall consist of nine active members of the Association and be constituted as a standing committee of the Council on

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Functions of the committee are to encourage and promote the private practice of medicine; to develop new methods that will promote private practice throughout medical school, graduate and postgraduate training; help the private practitioner improve his method of providing medical care (including business practices and utilization of allies); publicize the merits of private practice; encourage and help the development of similar committees by state medical associations; and maintain constant liaison with other committees and councils of the AMA to achieve those objectives.

MEDICINE AND GOVERNMENT

The House adopted a report explaining the Comprehensive Health Planning and Regional Medical Programs and their interrelations. It also:

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Affirmed its support of the concept of Regional Medical Programs as enacted in PL 89-239 and urged members to help guide Regional Medical Programs in line with the highest tradition of the private practice of medicine.

Expressed its "firm opposition to on-site auditing in physicians' offices of tax-supported programs by representatives of governmental agencies" and urged that problems between physicians and intermediaries or between physicians and governmental agencies be referred to local peer review committees.

Reaffirmed the AMA's official position that it will help federal agencies in "their quest for physicians who are errant in their participation in providing medical services to medicare and medicaid patients."

Opposed federal physician licensing and encouraged "state medical associations to work with their state legislatures to strengthen state laws, if necessary, to better control the few physicians who would tarnish the image of the whole profession."

Accepted a role of leadership in devising innovative programs for improving the operation of the medicaid program by utilizing existing mechanisms for the financing and delivery of health services within the private sector of the economy. In connection with pilot programs under Title XIX, the House resolved that "the Department of Health, Education and Welfare spell out the basic insurance requirements, setting forth the minimum benefits specified by law, which the states might place to bid."

Resolved to continue activities aimed at insuring that "in all matters relating to the health of the public and the practice of medicine, liaison between the appropriate federal officers, departments and agencies is conducted directly with the American Medical Association."

Opposed legislation requiring the filing of information reports by insurance carriers or other third-party payers of payments made to patients, since the reports would not necessarily indicate what, if any, payment was made to physicians.

Opposed, "in conjunction with other professional organizations . . . the Senate Finance Committee amendment which militates against professional corporations."

COST OF CARE

Expressing deep concern about the ever-increasing costs of hospital care services, the House resolved that the "AMA Board of Trustees request the Board of Trustees of the American Hospital Association to join with it in urging hospital boards and hospital medical staffs to develop and institute cost control measures for hospital care services."

The House also resolved that it "reaffirms its endorsement of the tax credit plan and urges the Board of Trustees to give this plan the strongest support and the widest publicity among members of the Association and the public." In addition, it urged AMA councils and committees to intensify efforts "to develop other realistic and effective plans of medical care coverage available for all persons in the United States, utilizing multiple methods of financing and free choice of mechanism based on adequate standards of coverage."

At the same time, the House urged all state medical associations to "submit promptly any other realistic proposals which they believe should be developed as AMA proposals for effective, widely available medical care insurance or prepayment plans."

Also in connection with cost, the House recognized that "various news media and agencies of the federal government routinely blame the medical profession for the rising costs of health care; and . . . some physicians and even the publications of the American Medical Association . . . use the erroneous expression health care when they should use the correct term medical care." The House resolved that "the Board of Trustees . . . initiate, promptly, remedial measures to clarify the meaning of the expressions 'medical care' and 'health care' and to assure their correct usage in all official publications of the American Medical Association" and that the executive vice president design activities "to correct the terminology of the lay press and enlighten the understanding of the public."

STRENGTHENING THE AMA

In his address, President Dorman made the following recommendation which the House referred to the Council on Constitution and Bylaws for study and possible action:

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"I would like to suggest . . . another category of membership . . . to include those members of the State Department, for instance, who are around the world taking care of our consular people; of our people in various countries and capitals of the world; who are not now eligible through membership in county societies to belong to the AMA. I would like to see a membership that is much like the membership of our armed forces, of our Veterans Administration or of our Public Health Service. These men look to us for advice and for leadership, and I would like to see us give them a home."

The House also urged state and county medical societies "to take action to make available to interns and residents active membership or its equivalent" and resolved that "the Council on Medical Education and other bodies within the American Medical Association intensify their efforts to initiate additional meetings and encourage continuing dialogue with medical students, preferably in conjunction with local chapters of SAMA; interns and residents in their respective states."

Recommending a continuing study of trends of membership in the AMA, the House resolved that the Board of Trustees "direct a task force to develop a realistic program to correct any cause which may result in a loss of potential physician members, and carry forward an active recruitment effort."

The House directed that the AMA "aggressively pursue close working relationships with the medical specialty societies" and adopted a Board report describing its recently created Commission on Foreign Medical Graduates.

A resolution was adopted strongly urging the Council on Medical Education and the specialty boards "to move forward with the acceptance of qualified osteopathic physicians into their training program and specialty board examinations." The House noted that the American Board of Internal Medicine is the sixth specialty board to declare that it will accept for examination graduates of osteopathic schools who have satisfactorily completed the requirements of the board in regard to approved internship, residency and fellowship training.

ADDITIONAL ACTIONS

At the Denver meeting, the House also:

Adopted a resolution suggesting that educational opportunity for students, interns and residents not be limited to university hospitals, but "expose these trainees to the merits of practice under a variety of environmental circumstances."

Resolved that the AMA, state and local medical societies "intensify their support of the private and public agencies in the fulfilling of their responsibilities in promoting environmental health."

Approved a report on professional liability that said "the feasibility of an AMA-sponsored professional liability insurance program is now being considered by the Board of Trustees."

Reaffirmed present policy on therapeutic abortion while rejecting a resolution that urged revision of state laws to permit abortion upon demand.

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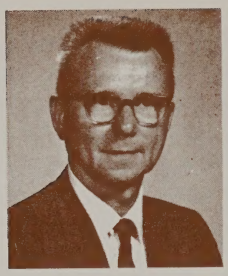

PRESIDENT'S PAGE

TURBULENCE

That the practice of medicine has always been associated with challenges and excitement is obvious to us all, but never perhaps, has there been a more turbulent and exciting generation than ours.

As one surveys the medical scene today, one naturally is disturbed by the rapid changes, the questioning attitudes, and the critical atmosphere. What will future developments bring? Can we anticipate and prognosticate with any accuracy? How will these changes affect each one of us personally? After all, isn't that the main reason why everyone, including the physician, is disturbed by change? Let us review some of these disturbing changes, these opposing philosophies, these revolutionary patterns, and their resulting unknowns.

PHYSICIAN SHORTAGE

First of all, let us begin with the problem of the shortage of physicians. In the early 1950's, the AMA repeatedly denied that there was a shortage of physicians. According to Dr. E. B. Howard, this position was arrived at on the basis of research conducted by an eminent economist who did not include in his calculations the increased supply necessary to accommodate the surging 1960's, when new legislation (i.e. Medicare), increasing affluence, and rising expectations would elevate markedly the number of physicians required to serve the nation. It was not until 1967, when these new developments and demands were highly operative, that the AMA officially adopted a new policy that clearly endorsed the belief expressed by many experts (i.e. U.S.P.H.S. studies) that an acute shortage existed.

But let us not single out the AMA for criticism. Who could have predicted with wisdom the developments of the past decade? Ten years ago the HDMS voted by a large majority that it was in favor of expanding the three existing medical schools in Massachusetts with moderate state support, rather than becoming exclusively embroiled in an expensive new state medical school construction program. The latter could be planned more efficiently as a long range project. This opinion was shared by the majority of our medical colleagues in

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this state. If this had been done, today we would have at least 500 more physicians in New England than we do. Moreover, our new state medical school would probably by now be functioning as a beginning two year program at the University of Massachusetts' campus in Amherst, where it should have been established in the first place and at much less cost to the state.

QUACKERY

This last item leads us to the subject of *health quackery,* which robs the public of an estimated two billion dollars annually and which the AMA has been fighting for years—at times under great difficulty because of interference from those who should instead have been cooperative and helpful. For example, an independent government study, without advice or interference by the medical profession, recommended continued exclusion of chiropractic from Medicare, and the National Senior Citizens Council published an indictment of chiropractic in its official newspaper; yet, our state legislators, by a vast majority, have just foisted this cult on our citizenry by legalizing its status, by insisting that its services (?) be covered by Massachusetts' Medical Service, and by continuing to support and expand it's unscientific practices.

COSTS

One of the most urgent problems facing the medical schools, the hospitals, and the practicing physicians is the cost of care and of medical education. Fifteen or more years ago the medical schools began to accept and later demand larger federal grants to be used presumably for research and education. This, broken down to lowest denomination, meant salaries for hundreds in new projects that were then undertaken by the medical schools. Certain more traditional and visionary educators warned even then that this practice could lead to severe difficulties in the future. That warning has been proven right. Our medical schools are currently in a state of chaos primarily due to cut back of federal funds—a practice which any student of political government knows can be predicted to occur cyclically.

At John Hopkins 61% of full time faculty receive some part of their salaries from federal sources, and 40% receive more than half from grants. At Tulane approximately 75% of the salary bill is covered by the government. Temple in Philadelphia has established two neighborhood health centers, elim-

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inated ward care, and replaced it's OPD clinics with a group practice system. But its losses are running at a rate of 1.8 million dollars per year, and its interest payment alone costs $5,400 per day.

One dean of an unnamed medical school has observed that before Medicare, the percentage of people over 65 visiting his institution's clinics was at least 20%. One year after Medicare, this percentage at the clinics had dropped to 2%. These old people, he remarked, are now visiting private physicians. But after all, wasn't that the intent of the Medicare legislation? And isn't that proof enough, that given an equal choice, the average American citizen will choose a private physician. Incidentally, are you aware that only 60% of all the physicians available are directly engaged in rendering medical care to patients?

What about the cost of care in local hospitals? Remember the fee for an OPD clinic visit just 4-5 years ago—approximately two dollars. Today it is probably 4 or 5 times higher. And are you aware that, if a patient visits an emergency room today and has a small finger laceration sutured with 3 or 4 sutures, his total bill will be over $50.00? Moreover, he still must see his private physician for follow-up. But let us not be hasty with criticism. The hospitals can explain this increase.

And how about the individual physician? Today he receives a fee for services which he rendered free to the indigent a few years ago and which fee may approximate 50% to 75% of his usual fee; but he is demanding his usual and customary fee. This is only right and should be so in these new times; otherwise, it would be an anachronism.

In conclusion, let us remember that with rapid changes we must be more flexible and be willing to admit that in predicting the future events and results, anyone and everyone can make errors. Yet, when all the turbulence has ceased, as it surely will, we can anticipate that most of the changes will be for the good.

May I close this discussion by offering a quote by the President of the United States, Richard M. Nixon:

"The central race in the world today is the race between man and change. The central question is whether we are to be the master of events, or the pawn of events."

Walter S. Mozdon, M.D.

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ONE MAN'S OPINION . . . . .

SHALL WE BECOME INVOLVED?

One of the few blessings of senior citizenship is the privilege to reminisce—like of the time when Fowler's Solution and the mustard plaster were the wonder drugs of the day or when the *village square* was a rendezvous rather than a synonym for the *rube* or *yokel*.

Another time that comes to mind is when our profession traditionally kept itself more or less *above* involvement in community affairs. Yes, we have always rendered free medical care to the poor, and we have always answered the call to participate in community health programs. However, it wasn't until about three decades ago that we actually began to initiate and to develop health projects on our own. In 1969, alone, Hampden District sponsored programs such as The Health Fair, Diabetes Week, Scholarship Funds, Regional Planning, Sex Education, Drug Abuse and Disaster Medical Care—to mention but a few. The question, therefore, is not whether we should get involved (as the title of this column querries) but whether we shouldn't widen and extend the scope of our commitments. AMA's President, Dr. Dorman, at our November meeting, provided the answer when he emphasized that District Societies should assume leadership in all community health planning. Similar opinions were expressed and acted upon at the last AMA Convention. For the first time in its history the AMA has committed itself to consult with "the poor" in developing medical service programs. It has also pledged itself to seek increased funding of "effective government programs for the health care of the poor and medically indigent."

SOLO VS. SOCIETY INVOLVEMENT

As citizens we naturally have a perfect right to participate in programs of our own choosing. But this in no way relates to what organized medicine is doing or is trying to do. Nor is it anywhere near as effective. The magazine section of *The New York Times* of November 9, 1969, carried an item by Dr. Michael Halberstam in which he admonishes that "The M.D. Should Not Try to Cure Society." This, in fact, was the title of his article. The author is especially disturbed about physicians who devote their time and energy to non-medical causes. He points out that "Each doctor . . . . lobbying for gun control,

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marching for peace in Vietnam or distributing petitions to abolish the Supreme Court is a doctor away from his patients or his research."

Another example of irrelevant solo activism cited by Dr. Halberstam, follows: "The medical students who dressed up in white coats and red armbands and appointed themselves 'physicians' to Coulmbia's striking students last spring were there primarily because they believed in the cause, secondly they were healers. They had every right to believe in the cause and to work for it, but playing doctor was hardly the best way to do so."

WHAT OTHERS ARE DOING

Our medical literature fairly bristles these days with reports of a great variety of community activities by District Societies throughout the land. A single request brought from the Director of the AMA's Library (Mrs. Susan Crawford) no less than fourteen pertinent and illuminating reprints. Space doesn't permit even a brief summary of their content, but their titles alone convey a great deal. Here are some of them: "The Scope and Responsibility of Medicine," "Physicians and the Governance of Hospitals," "The Role of the Physician in Areawide Planning," "County Society Runs a Clinic for California Farm Laborers," "Atlanta MD's Push a Plan for Medical Care of Poor," "A role for Medicine in a New Era of Health Care," and "How the Medical Profession and Government Can Communicate More Effectively."

An analysis of the material headed by these titles leads to several inescapable conclusions. The most important of these were best expressed in the specific recommendations by Dr. C. L. Hudson, a past president of the AMA: "First, the local medical society must make a public commitment. It must put itself and its members on the line as undertaking the establishment of a comprehensive community health system."

"Second, it must take the initiative in drawing together all of the elements of the community that have a legitimate interest in health care, to mobilize their combined efforts in a study of existing health facilities and existing needs within the community."

Another conclusion of interest is the recognition that health problems of the poor are not isolated problems, but are, in the words of one AMA spokesman, ". . . . most often concomitant with other socioenvironmental issues, such as poor housing, malnutrition, underemployment and insufficient education."

In addition, there are other activities and suggestions worthy at least of brief mention. One of them, again favored by the AMA, is that an elected representative of the medical staff be appointed to the governing board of each hospital. Finally, there is the suggestion that our profession participate with other segments of society to find solutions for the new ethical problems created by modern technology and mores, such as organ transplantation, artificial insemination, abortion laws, etc.

In short, District and County medical societies are being called upon to provide their expertise, advice and guidance to lead their communities toward better health. Over and over again it is emphasized in the above reports that if we fail to do so, someone else—much to the detriment of the public and our profession—will come along and do it.

Millman

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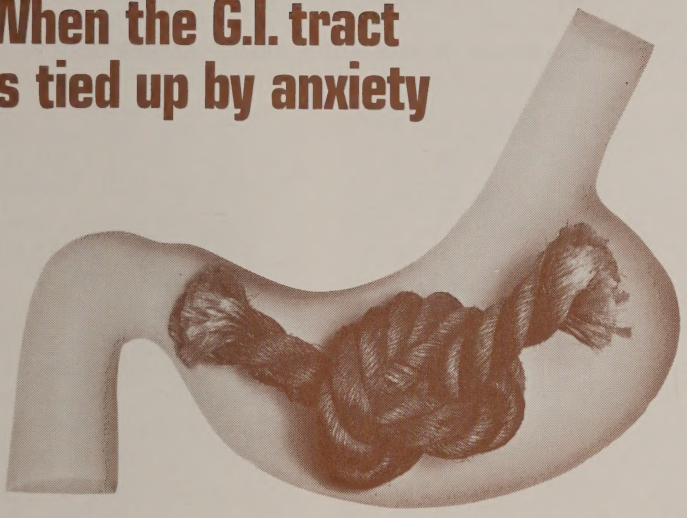

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Contraindications: Patients with glaucoma, pyloric obstruction, prostatic hypertrophy, bladder neck obstruction, obstructive intestinal lesions and/or ileus. Nausea and vomiting associated with intestinal obstruction or brain tumor.

Precautions: Caution patients about activities requiring mental alertness (driving, hazardous occupations). Keep patients under regular observation. Additional depressant effect is possible when used with other C.N.S. depressants. Patients sensitive to other drugs may be more liable to have a reaction to prochlorperazine. Use with caution in elderly patients. Use in pregnancy, lactation, and in women of childbearing age only when necessary. Discontinue one week prior to I^{131} uptake and PBI tests, as the iodine in isopropamide iodide may alter results.

Adverse Reactions: Drowsiness, dizziness, amenorrhea, skin reactions, dry mouth, blurred vision, urinary retention, dilated pupils, photophobia, constipation and tachycardia. Palpitation, nausea, dysphagia, fever, and nasal congestion, rarely. Hypotension, agranulocytosis, cholestatic jaundice, leukopenia, extrapyramidal symptoms (motor restlessness, dystonias, pseudo-parkinsonism) have occurred with prochlorperazine.

Other Adverse Effects reported with one or more phenothiazines: Some adverse effects are dose-related, others involve patient sensitivity, some occur more frequently in patients with special medical problems, for example, mitral insufficiency or pheochromocytoma. Opisthotonos, oculogyric crisis, hyperreflexia, dyskinesia, sometimes lasting months or years; *grand mal* convulsions; altered cerebrospinal fluid proteins; cerebral edema; potentiation of C.N.S. depressants, atropine, heat and phosphorus insecticides; headache, adynamic ileus, inhibition of ejaculation; reactivation of psychotic processes, catatonic-like states, hypotension (sometimes fatal); cardiac arrest; pancytopenia, thrombocytopenic purpura, eosinophilia; lactation, galactorrhea, gynecomastia, menstrual irregularities, false positive pregnancy tests; photosensitivity, itching, erythema, urticaria, eczema, exfoliative dermatitis; asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions; peripheral edema; reversed epinephrine effect; hyperpyrexia; pigmentary retinopathy; with prolonged administration of substantial doses, skin pigmentation, epithelial keratopathy, and lenticular and corneal deposits.

EKG changes—particularly nonspecific, usually reversible Q and T wave distortions—have been reported, but relationship to myocardial damage is not confirmed. Sudden discontinuance in long-term patients may cause temporary nausea, vomiting, dizziness, tremulousness.

NOTE: Sudden death has been reported though a relationship to phenothiazine administration has not been determined. In some cases the cause appeared to be asphyxia due to failure of the cough reflex; in others, no cause could be determined.

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STUDENT AID
VOX CLAMANTIS IN DESERTO?

by

B. LINCOLN WALES, JR., M.D.

CHAIRMAN, HDMS SCHOLARSHIP COMMITTEE

For five years the HDMS has had a Scholarship Committee which was initially planned and headed by the late Dr. Ralph T. Miller of Ware, former president of HDMS. The donations collected by the HDMS during the polio immunization program in 1964 still form the sole basis for the interest income which we disburse annually to help students of medicine, pharmacy, and nursing who reside in Hampden County. Over the years, we have made outright awards totalling $4,355.00 to a total of sixteen students. Ten of these were medical students, and six were nursing students. Three students of pharmacy had also been chosen as recipients in this period, but in each case their financial problems were solved otherwise before final scholarship selections were made by the Committee.

Through Dr. Ralph Miller's interest and energetic attention in 1964, the pressing problem of efficient management of the polio fund was determined to be best accomplished by depositing it under the aegis of the Charitable and Educational Fund of the Massachusetts Medical Society. With the recommendation of legal counsel of the MMS and of our own legal advisor an agreement with the directors of that Fund was drawn, and approval voted by the HDMS on December 1, 1964, to permit disbursement of the annual interest for scholarship grants, without paying taxes to the Internal Revenue Service. If the latter had become necessary, the HDMS would have had to become involved in a tedious and lengthy exchange with the Boston and Washington offices of the federal tax bureau. I believe a period of five years had been necessary for the creation of the MMS's separate Charitable and Educational Fund as an entity which could receive and disburse funds for financial aid purposes.

This year the HDMS Scholarship Committee has come to realize that further efforts should be made by the five hundred and twelve (512) physicians in the HDMS to increase the

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amount of available scholarship money. Last year, for example, awards were made to five of seventeen applicants who completed their applications. Most, if not all, of these seventeen students could have been helped by scholarship grants or loans from sources beyond their families' ability to provide. Although the marked annual increase in educational costs is known to everyone, the point is more acutely emphasized by the fact that in 1968-69 56% of the 35,833 students enrolled in medical schools alone received scholarship aid or loans through their medical schools. This figure does not acknowledge any of the individual efforts made by students and their families through private sources, or by such separate aid as a grant from the HDMS. This is a problem in our own locality which some now feel should be given greater attention by the physicians of this Society.

In an effort to obtain a better idea of what the district societies throughout Massachusetts are doing to meet the financial needs of students, all were contacted, and I find that we are not alone in our scholarship efforts. As a matter of fact, in comparison with some districts we are distinctly behind in the amount of effort being made to provide financial aid. Of the nineteen district societies contacted, replies have been received from twelve. Six had plans varying from outright grants to loans to be repaid up to six years after graduation from medical school. One district society has undertaken to provide the full annual expenses of a medical student at one of our Boston medical schools. Another of the district societies has a separate educational fund with "its own charter from the Secretary of State". Its treasurer transfers each year the sum of money to be invested for this purpose, In addition, that same district society makes two gifts

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ATTENTION COMMITTEE CHAIRMEN!

Committee reports that are purely informational in character need not be presented at the Annual Meeting. Instead, they will be published in the April issue of the *Hippocrat*.

The only requirements are: (1) that the report not exceed 300 words and (2) that the original report and a copy reach the Society's headquarters not later than March 9. A copy of the report is necessary for printing in the *Hippocrat*.

Reports containing "recommendations" will have to be presented at the Annual Meeting.

Chairmen of sub-committees are not expected to present reports at the Annual Meeting; rather, they are to report to their respective parent committees.

Your cooperation is urgently requested.

Bruce B. Stoler MD

BRUCE B. STOLER, M.D., *Secretary*

of money to student nurses, presumably directly from its treasury. Another district provides $500 a year, up to four years, for loans to residents of their district. Their funds have been derived from an annual assessment to each member of their district society. Another district has established a revolving loan fund with an award up to $1,000 given to a student for an academic year, renewable for three years. Since 1966 that particular dis trict has offered four scholarships each for a $1,000 maximum, renewable for three years. That same district society has gone further in asking their medical student recipients to at least consider serving internships in the hospitals of the county.

The Connecticut Valley Dental Society has a revolving loan fund of its own providing aid to dental students from this area. Our own woman's auxiliary has also performed an outstanding service over the years through its scholarships for nurses, amounting to $25,790.00.

All of the foregoing programs are mentioned for the purpose of pointing out that the HDMS scholarship arrangements at this time are limited by legal restrictions on the sources of the funds. Freer use of larger amounts of money from other sources could be made if the individual physicians of the HDMS were directly involved in providing such additional scholarship aid as some state societies already give.

The Executive Committee at its December meeting has directed further study on the possibility of increasing the amounts available for students, and the Scholarship Committee is presently involved in exploring this further.

Figures and percentages are often irritating and impersonal, but when seen in terms of these students who apply to us for help, their translation into personal needs of young people hoping to become nurses, pharmacists, and physicians becomes easier. The physicians who have worked on the Scholarship Committee during these years, I think, would equate their committee efforts with the positive and pleasant satisfactions which each physician in practice has occasionally realized in his own experience with patients. Every one on the committee hopes that every member of the HDMS will give higher priority in his thinking in the future to this increasing problem of financial assistance for these new students of nursing, medicine, and pharmacy, who look with high hopes to their futures, and thereby, to the improvement of the health of the people to which all physicians are dedicated.

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MASSACHUSETTS MEDICAL BENEVOLENT SOCIETY

by

ROBERT W. BUCK, M.D., SECRETARY

Five physicians and 16 widows of physicians currently derive a measure of support from the funds of the Society. Individual annual grants range from $400 to $2500. These grants merely serve to supplement inadequate income from other sources such as insurance, pensions, social security, Medicare, and private charity, including professional courtesies on the part of hospitals and physicians. The benevolence of the Society usually barely suffices to bring the total income of the recipient up to subsistence levels.

A young physician's widow earns $100 a week toward the support of her self and her children. This falls far short of her needs. Another middle aged widow earns $237 a month (net). This, plus $110 from the rent of an apartment in the house left her by her husband does not cover the needs of herself and two children. An elderly physician is dying of cancer, and the valiant efforts of his only daughter, who earns a little more than $100 a week, his wife, who gives a few piano lessons, and the pittance he still earns from attending patients, suffice to bring in only $600 a month. His last hospital bill amounted to $5,300.00! Another widow is deprived of what might have been a living from her husband's estate had it not been dissipated through his terminal financial and other vagaries.

The fellows of the Massachusetts Medical Society would be shocked if the identity of some of the Benevolent Society's beneficiaries could be revealed. The roster has continuously included eminent specialists and successful general practitioners, their widows, and their children. On occasion, especially in the case of young doctors who have encountered disaster, the help of the Benevolent Society has enabled a widow to survive a period of readjustment, and to achieve a measure of financial security, after the education of her children has been accomplished.

It is dismaying to realize that in an affluent society, destitution is still prevalent. This is perhaps in part due to the inflation of our currency, which in turn may result from the ineffective use of state and federal funds, and the increasing burden of taxation. Whatever the cause of persistent poverty, private charity is still essential for the dignified survival of its victims.

Every physician if he can afford it, should feel privileged to annually contribute $10 sustaining dues to the Massachusetts Medical Benevolent Society.

Applications for membership should be addressed, enclosing a check for $10, to the Treasurer of the Society, Dr. Charles G. Shedd, 1180 Beacon Street, Brookline, Massachusetts, 02146.

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SPRINGFIELD'S MORTALITY STATS

An unofficial anaylsis of death certificates filed in the City of Springfield for residents thereof in 1969 reveals that a total of 1,645 persons died therein during the year. This figure does not include those Springfield residents who died outside of the City nor the 867 deaths of non-residents occurring in the City.

TEN LEADING CAUSES OF DEATH

1.	Diseases of the heart	661
2.	Neoplasms	290
3.	Cerebrovascular lesions	207
4.	Pneumonia (all types)	108
5.	Accidents	84
6.	Cirrhosis of liver	48
7.	Diseases of the circulatory system	47
8.	Bronchitis	43
9.	Diseases of early infancy (under 4 weeks of life)	35
10.	General arteriosclerosis	24
	All other causes	98
	Total	1,645

Deaths from heart disease lead the list with 40.2%; next, neoplasms with 17.7%; third, cerebrovascular lesions with 12.6%; fourth, pneumonia with 6.6%; and fifth, accidents with 5.1%. Approximately, three-fourths of the deaths occurred in those 60 years of age and above. Males predominated over females in the ratio of 1.05 to 1. The trend, as in the recent past, again points up the fact that chronic diseases, particularly those of the cardiovascular system in the older age groups are the major killers of Springfield residents.

Death from infectious diseases were due to:

Pneumonia	108
Bronchitis	43
Meningitis	2
Tuberculosis	1
Total	154

Only 3 deaths were due to infectious diseases considered officially dangerous to the public health. Most of the pneumonia and bronchitis deaths were undoubtedly fatal precipitations superimposed on some other debilitating disease.

Analyzing the 84 deaths occurring to 54 men and 30 women as the result of accidents, the following interesting facts present themselves. First, 37 or close to one-half occurred in or about the house as the result of falls involving 17 men and 20 women primarily in the older age group. Secondly, 28 persons were killed as the result of traffic accidents—5 drivers, 6 passengers, 13 pedestrians, 3 motorcyclists, and one involving a school bus. Five died of burns and 2 drowned. One death respectively resulted from the following; blunt force injury to head, crush injury by being caught in a lathe, exposure to cold, furniture falling on and crushing a child, stepping on a high tension wire, chronic lead paint ingestion, barbiturate overdosage, morphine overdosage, perforation of rectum, sodium pentothal anesthesia overdosage, stab wound by falling on screwdriver, and striking of leg severely while at work.

It might be pointed out for mental health connotations, that there were 7 suicides (3 males and 4 females) with deaths beginning in the 20-29 year age group and occurring in virtually each ten year grouping up to and including the 80 plus group. Moreover, there were 10 deaths associated with homicides (9 males and 1 female).

There was one death resulting from complications of pregnancy (a maternal death) and 22 stillbirths reported. Fifty-four infants (under 1 year of age) died with 35 due to prematurity, 4 due to pneumonia, 4 due to diseases of the circulatory system, 3 due to disease of skin and cellular tissue, 2 each respectively due to congenital malformations and homicide, and 1 each respectively due to neoplasm, cerebrovascular accident, accident, and ill-defined causes.

Ayres

THE NEXT MEETING OF THE SPRINGFIELD ACADEMY OF MEDICINE

WILL BE HELD ON

TUESDAY, MARCH 10, 1970, AT 8:30 P.M.

SPEAKER: DANIEL D. FEDERMAN, M.D.
Associate Physician
Mass. General Hospital

TOPIC: "The Nature(s) of Sex"

CLINIC: Wesson Women's Hospital, 5:00 P.M.

HIGHLIGHTS OF THE JANUARY EXECUTIVE COMMITTEE MEETING

The January Executive Committee meeting was held on Tuesday, the 20th in the Conference Room of the HDMS. Dr. Mozden, President, called the meeting to order at 8:10 P.M. Present were Drs. Mozden, Stoler, Boivin, Collard, Barnes, Moore, Anton, Cummings, Sullivan, Kelly and Mrs. Purdy.

The minutes of the December meeting were read by Dr. Stoler and accepted as written.

CORRESPONDENCE

A copy of a letter sent by Dr. Susat to MMS resigning from the AMA with reasons therefor was read. Dr. Fine, President of MMS and Dr. Hayes, delegate to the House of Delegates of the AMA had both answered Dr. Susat. Dr. Susat's final letter to Dr. Hayes stated that he hadn't changed his mind about AMA membership.

A letter of resignation as Vice President and President-Elect from Dr. Collard to Dr. Mozden was read. The Executive Committee accepted this resignation with regrets.

Dr. Griffin wrote about the hospital medical staff coverage of the Red Cross bloodmobiles. His complaint seemed to be concerned with the added burden to physicians who are on more than one hospital staff. After discussion, Dr. Sullivan stated that he would cooperate with Dr. Rini of the Mercy Hospital and Dr. Kahn of the Wesson Memorial Hospital to make a roster so that coverage would be spread out more equitably.

A letter from Dr. Gallagher with support by several telephone calls from other physicians was discussed. A complaint was registered and appropriate action was requested in regard to the newest edict from the Massachusetts Department of Public Welfare wherein it is stated that the interpretation of the Massachusetts Attorney General of Chapter 885 of the Acts of 1969, section 5c, makes it mandatory for a copy of a bill for services rendered be sent to the recipient of Medicaid as well as the Massachusetts Department of Public Welfare. It was decided to find out more about this from MMS particu-

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larly since Dr. Mozden, Dr. Boivin and Mrs. Purdy are to attend the President's Conference on January 21st.

COMMITTEE REPORTS

A Mental Health Committee report was read as informational.

The Evaluation of an Opinion Study conducted by the Inter-Hospital and Community Health Planning Committee of the HDMS regarding the Western Massachusetts Hospital was read. The Executive Committee approved the report.

OLD BUSINESS

The question of the Allan Photographers coming into the District to take pictures of the physicians was discussed. Dr. Hough had talked with two physicians in the middle west about this and with certain reservations it was passed by the Committee to allow the Allan photographers to move in and take the pictures.

As there has been no report from the Ethics & Discipline Committee of the MMS about the Massachusetts General Hospital's solicitations, this was tabled for another month. The Committee is scheduled to meet on January 28, 1970, according to Dr. Gephart.

A report of the Scholarship Committee was informational. Dr. Wales presented an excellent report with copies for each member of the Committee.

It was voted to change the name of the Emergency Medical Service Committee to the Medical Information Service Committee.

NEW BUSINESS

Dr. Mozden appointed Dr. John Prybylo to replace Dr. Richard Paul as a Councilor to the MMS. This was approved by the Committee.

Dr. Mozden announced that he had consulted with the Nominating Committee and that he was recommending the name of Dr. John W. Turner to take over as Vice-President, President-Elect. This was approved by the Executive Committee.

Dr. Ayres, Executive Councilor to the MMS, gave a report on the MMS's Executive Committee meeting held in Boston on January 14.

Dr. Mozden spoke briefly on the importance of peer review and the importance of appointing a committee for peer review. He also mentioned that Dr. Hayes would be speaking about this subject at the District meeting to be held on February 3 at the Storrowton Tavern. Consideration of establishing such a committee was postponed until the February Executive Committee meeting.

The meeting was adjourned at 10:30 P.M.

The Grievance Committee met and heard two cases. Letters will be written to both parties.

The meeting was adjourned at 11:05 P.M.

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HAMPDEN CAPSULES

Dr. Robert Emery was chosen to receive the 20th Outstanding Citizen Award of Greater Springfield—Freedman Post 26—Jewish War Veterans.

Dr. Ashton has retired after 35 years in practice.

Dr. Sidney Nathans was written up in the Alumni News of AIC as inspiring new graduates to go into nursing home work.

Dr. John Larson was written up in Union Profile of the Springfield Union.

Dr. Robert Emery spoke to the practical nurses graduating from Springfield Trade High School.

The Heart Fund Kickoff Dinner was attended by quite a few physicians and Dr. Weisman was guest speaker.

Dr. Garry DeN. Hough presented a check to the Northern Educational Service from the South Congregational Church Benevolence Committee.

Dr. Robert M. Abrams, medical advisor of the Pioneer Valley Chapter of the National Foundation, helped to kick off the fund drive in Holyoke.

Paintings and graphics from the private collection of Dr. and Mrs. Malcolm W. Bick were on display at the new restaurant Picot's in Hampden.

Portrait paintings of Drs. Bagg and Allen were recently presented to Holyoke Hospital by their families.

Mrs. Purdy attended a conference for Senior Medical Executives held in Chicago on January 28-29 by the AMA.

SPEAKERS

Dr. Stelle-Perkins, an applicant to HDMS, spoke to the Pioneer Valley Medical Technologists on "Diagnosis of Urinary Tract Infections in Children."

Dr. James Visconti spoke on heart and circulatory diseases as a threat to the health of Americans at a meeting of the Women's Missionary League of the Grace Lutheran Church.

Dr. Stephen Daly was guest speaker at the meeting of the Massachusetts Podiatry Society and spoke on "Patient Psychology."

Dr. Garry DeN. Hough spoke at the YMCA's monthly meeting of the Community Concern Forum, with the topic, "A Doctor Looks at the New Morality."

Dr. William Romanos spoke on drug abuse at Brunton School, Sacred Heart, Talmadge, and quite a few others.

Dr. Lestor Suzor spoke on drug abuse at St. Anne's Guild at Mt. Carmel School.

Dr. B. A. Galuszka has been keeping the movie "Human Growth" busy at different meetings in Chicopee.

The drug abuse movie, "Escape to Nowhere," is constantly being used. The audio-visual section of the Holyoke schools have used it, the Longmeadow schools and the LPN section of Trade High School keep it busy.

Dr. Daniel Hart spoke to Women's Auxiliary of Springfield Hospital Medical Center on the latter's involvement in the Riverview Housing Project.

Drs. William Davis, Frederick Flatow and Eckart Sachsse took part in a panel discussion on "What is Leukemia?", sponsored by Western Massachusetts Chapter, Leukemia Society of America.

Edward F. O'Donnell
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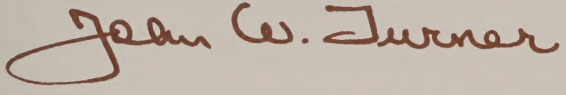
YOUR COMMITTEE OF CHOICE

In order to insure the widest possible participation in the H.D.M.S.'s affairs, I am hereby inviting and urging members who have a particular interest to name the committee on which they would like to serve. Needless to say, the effectiveness of a committee is in direct proportion to the interest and concern of its members.

In the forepart of the *Hippocrat* is a complete listing of the Society's committees. Simply by dropping a note or calling the H.D.M.S. office at 1414 State St., Springfield, Mass. 01109, your interest and preference will be given most serious consideration for appointment. Moreover, you will be rendering a distinct service to your profession, your community, and your Society.

Committee work is the heart of any organization. I urge you to let us know where you wish to apply your talents and energies.



John W. Turner, M.D.
Vice President and President-Elect

MARK YOUR CALENDAR NOW!

HDMS Annual Meeting, April 28

HDMS Executive Committee Meetings, March 17 and April 21

MMS Annual Council Meeting, Boston, May 20

MMS Annual Meeting, Boston, May 26-28

New England Hospital Assembly, Boston, March 22-25

American College of Surgeons (Sectional), Washington, D.C., March 16-18

AMA National Congress on Socio-Economics of Health Care, Chicago, March 20-21

Association for the Advancement of Medical Instrumentation, Boston, March 23-25

AMA Annual Meeting, Chicago, June 21-25

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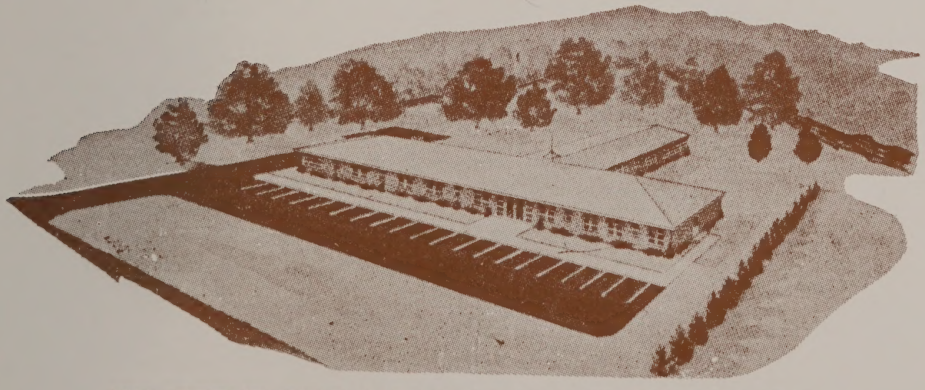

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